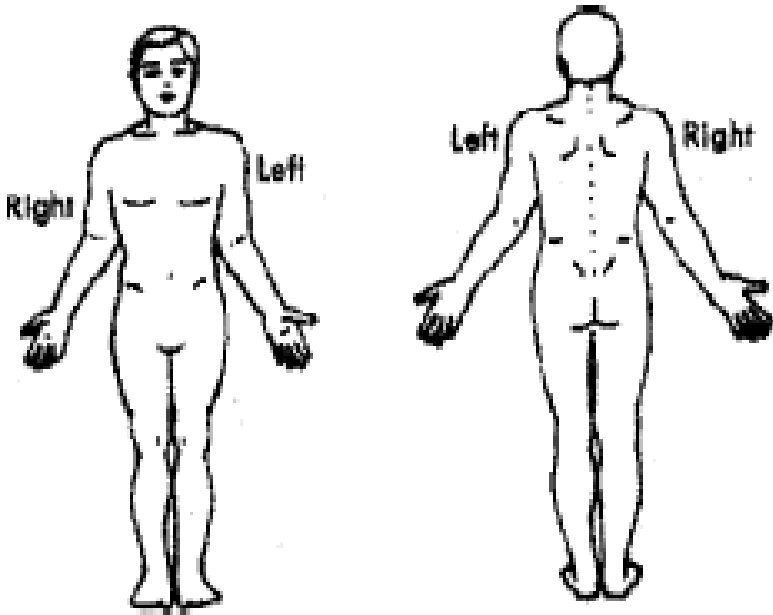


Body Pain Scale & Medical History

Pain Rating Scale:

Using the number rating system (0 = No pain – 10 = Severe Pain), describe your:

	Pain level NOW:		(0-10)
In the past 30 days	Pain level at BEST:		(0-10)
In the past 30 days	Pain level at WORST:		(0-10)



Use the symbols listed below to describe the location and type of pain or unusual feelings you are having by drawing them on the picture(s).

OOOO	Pins and Needles
XXXX	Numbness
/////	Pain
=====	Other

Past Medical History

Please briefly describe any medical conditions or pertinent information regarding your past medical history:
Have you ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please briefly explain and give the date(s).
Do you have any allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list below.
Are you presently taking any medication(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list below.
How did you hear about us? Please list below.

Electrodes

Use of electrodes may be necessary in your treatment plan. Electrodes are not covered by insurance plans. Personal electrodes may be purchased for \$5.00 (non-refundable). General electrodes (multiple users) are also available in the office at no cost to you. Please indicate if you would like to purchase personal electrodes OR prefer using the general electrodes.

Personal electrodes (\$5.00 due at time of first use) OR General electrodes

Therabands

Issuance of Therabands may be necessary in your treatment plan for exercises to be completed at home. Therabands are not covered by insurance plans. The cost for Therabands is \$5.00 (non-refundable) and is due when a Therband is issued.

Patient Signature: _____ Date: _____
(Parent or Guardian if patient is a minor)